Incident Report: Writing

What is an Incident Report?

› An incident report (IR; also called accident report and an occurrence report) is a written, confidential record of the details of an unexpected occurrence (e.g., a patient fall or administration of the wrong medication) or a sentinel event (i.e., defined by The Joint Commission [TJC] as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof) involving a patient, employee, or other person (e.g., a visitor) who is present in the healthcare facility. An IR is used for internal risk management and quality improvement purposes, and is not part of—nor is it mentioned in—the permanent patient record if a patient is involved. An IR should be completed each time an event occurs that deviates from the normal operation of the facility (e.g., a visitor falls) or deviates from routine patient care (e.g., a medication error)

• **What**: The purpose for writing an IR is to document the details of an unexpected occurrence or sentinel event. The written information is analyzed to identity changes that need to be made in the facility or in facility processes to prevent recurrence of the event and promote overall safety and quality health care

• **How**: Writing an IR involves providing an objective, detailed description of what happened; typically the healthcare facility has a standardized form that is completed by the person who witnesses the incident or is responsible for the area in which the incident occurred in the case of an unwitnessed incident. The documented information can vary, but typically an IR includes details regarding
  – who witnessed the incident, which is typically the person reporting the incident although in some cases there is more than one witness
  – who was affected by the incident (e.g., patient, family member, nurse)
  – what persons were notified (e.g., treating clinician, fire department)
  – what actions or interventions were performed in response to the incident
  – the condition of the patient, visitor, or employee who was affected by the incident

• **Where**: An IR should be completed in all healthcare settings according to facility protocol

• **Who**: IRs can be completed by any licensed healthcare professional who participated in or witnessed an incident. Writing an IR should never be delegated to unlicensed personnel—although unlicensed personnel should report any witnessed incidents and provide information that can be included in the IR—and are rarely completed in the presence of a patient’s family members

What is the Desired Outcome of Writing an Incident Report?

› The desired outcome of writing an IR is to

• document the occurrence of an unexpected event that involves physical or psychological injury to a patient, visitor or employee or that increases the risk for injury

• identity changes that need to be made in the facility or to facility processes in order to prevent recurrence of the event and promote overall safety and quality health care

Why is Writing an Incident Report Important?

› Writing an IR is important because it can provide

• documentation of quality of care
• information that can help clinicians and administrators evaluate and collaborate to reduce the incidence of patient care errors and other incidents
• a contemporary record by witnesses of the incident that can be useful in resolving liability issues

Facts and Figures
› In an observational study conducted in 10 internal medicine departments in 8 Dutch hospitals over the course of 5–14 weeks, investigators found that 42% of the 625 unexpected events reported by hospital staff members were related to medication, and 10% of events involved patient injury (Lubberding et al., 2011)
› An analysis of IRs regarding medical imaging-related incidents in a teaching hospital in Australia determined that 49% of incidents were associated with a breakdown in communication (Maeder et al., 2012). Researchers who reviewed a compilation of information from 15 studies identified the following as reasons why clinical errors are unreported (Wolf et al., 2008):
  • Clinicians’ fears about being considered incompetent, potential legal liability, and the lack of anonymity of documented persons in the IR
  • Lack of information about the error/event and how clinical errors are defined
  • Disagreement with the organization definition of clinical error and/or which errors should be reported
  • The belief that IRs have no benefit
  • Disappointment in the response of administration to prior IR filings
  • Belief that the IR process requires too much time and/or effort
› In a study of 1,180 nurse clinicians working in the nursing home setting, researchers found that study participants considered error reporting to be a difficult process; likelihood of reporting a serious error was higher in nurses who had reported a serious error in the past (Wagner et al., 2011)
› The decision regarding whether or not an incident has occurred—and whether or not to complete an IR—is made based on nursing judgment, which varies among nurses as a result of differences in area of nursing practice and experience. Many nurses are hesitant to complete an IR if little or no patient harm resulted from the incident (Waters et al., 2012)
› Medication errors may result in an adverse event. A systematic review demonstrated underreporting of adverse drug events occurred in 17 countries; the majority of underreporting occurred in Germany, Spain, Holland, England, Ireland, Portugal, the United Kingdom, and Sweden. Authors conclude lack of training in the concepts and processes of pharmacovigilance for healthcare professionals is the main cause for underreporting (Varallo et al., 2014)

What You Need to Know Before Writing an Incident Report
› Safety is the first priority when incidents occur. IRs should be completed only after the condition of the involved patient, visitor, and/or employee is assessed and appropriate nursing and medical interventions are implemented in response to the incident
  • If the incident involves a patient, the treating clinician should be notified immediately and interventions that are ordered should be performed. If the incident involves a visitor, he/she may require transport to the emergency department for evaluation and treatment. If the incident involves an employee, transport to employee health or the emergency department may be indicated, depending on the degree of injury
› IRs are a necessary component of quality improvement efforts. IRs are analyzed in order to learn exactly what happened, identify the root cause (i.e., underlying factors), and predict if the incident is likely to recur. Analysis of IRs identifies changes that need to be made in the facility or in facility processes to prevent recurrence of the incident and promote overall safety and quality of care. Failure to report incidents prevents the organization from developing and implementing policies and procedures to prevent the incident from recurring
  • Incidents are not limited medical errors or to errors in patient care, but include any unexpected occurrence in the healthcare facility; examples of incidents that do not involve patients include a visitor falling, a visitor contracting an illness while in the hospital, and a facility employee tripping over a cord, being injured by a piece of malfunctioning equipment, or being assaulted by a visitor
  • An IR must be completed within a specified period of time, typically within 24 hours of the incident, and delivered to a nurse manager or to the risk management department according to facility protocol. Completing the IR as close to the time of the incident as possible results in a more accurate IR
› IRs should be completed for all unexpected occurrences regardless of the degree of harm that occurred or who was involved. Completing an IR is mandatory for incidents involving patient injury and in the case of sentinel events because these signal the need for immediate investigation and response, and should be completed if the incident placed a patient, visitor, and/or
employee at increased risk for harm even if no obvious harm occurred. Incidents that do not result in harm are still indicative of facility processes that compromise safety in the organization

- Errors associated with the administration of medication (i.e., errors related to inaccurate prescribing, administration of the wrong medication, improper administration of the correct medication, omitted doses, and administering unscheduled doses) are some of the most common types of potentially serious patient care errors. Other common reasons for completing an IR include injury to a patient, visitor, or employee and medical device malfunctions
- According to The Joint Commission (TJC), healthcare organizations and leaders in healthcare organizations must develop a culture of safety in which there is constant striving for safety; safety must be a primary goal of the organization as demonstrated by the actions of administrative and clinical leaders. Transparency in the organization is necessary with regard to errors such that when errors occur, information regarding the error is shared openly and there is a clear and established process regarding possible disciplinary action. The focus, however, of reporting an error is not to discipline employees but to initiate a thorough evaluation of the error to reduce the chances that it will be repeated. Clinicians who report patient care errors should be protected from professional retribution and improper disciplinary action; facility emphasis on disciplinary action will result in clinicians not reporting incidents (TJC, 2009)
- Organizations must strive to have a culture of safety, not a punitive culture, in order for personnel to feel safe reporting incidents
- Healthcare professionals have an ethical responsibility to report medical errors (Wolf et al., 2008)
- In 2009, TJC released 14 recommendations designed to support transparency in organizations (for details, see http://www.jointcommission.org/assets/1/18/SEA_43.PDF

- An IR is not part of the patient’s medical record and is not mentioned or referred to in the patient’s medical record because the medical record is patient-focused and only includes information that is pertinent to patient care. The IR is intended for use in risk management and should include information that does not pertain to patient care such as the names of witnesses who were present at the time of the incident. What should be included in the patient’s medical record is an objective description of what was observed to have happened, patient assessment information, interventions performed, and patient outcome. Depending on the circumstances of the incident and the severity of the outcome, the nurse or the healthcare facility may be required to report it to TJC, MedWatch (i.e., a medical products reporting system that is part of the U.S. Food and Drug Administration), and/or the U.S. Pharmacopeia Medication Errors Reporting Program

How to Write an Incident Report

- Use clinical reasoning and judgment to confirm that an incident has occurred that requires completion of an IR
- Complete an IR even if it is likely to result in disciplinary action and whether or not direct harm has occurred
- Meet and document the statements of the principal parties and witnesses to the event, if applicable
- If information must be obtained from patient or visitors, determine if they require special communication considerations (e.g., due to illiteracy, language barriers, or deafness); make arrangements to meet these needs if they are present
- Use professional certified medical interpreters, either in person or via telephone, when language barriers exist
- If applicable, assess anxiety level and coping ability of the patient, visitor, or employee involved in the incident; assess for knowledge deficits regarding writing an IR and provide additional information and emotional support as needed
- Complete the IR form, including but not limited to documenting the following information:
  - The identification of the patient, visitor, or employee
  - Location, time, and date of the incident
  - Names of persons other than the patient/visitor/employee who were involved in the incident, including those who witnessed but did not participate in the event
- Physical and emotional status of the patient/visitor/employee before and after the incident
- A detailed, objective description of the incident
- Statements made by the patient/visitor/employee at the time of the incident, which should be quoted verbatim in the IR
- Medical and nursing interventions performed and the affected individual’s response
- Whether or not a treating clinician was contacted for an involved patient, the time of the contact, and if the treating clinician assessed the patient
- Any additional actions performed (e.g., referral of visitor to the emergency department, malfunctioning equipment sent to the materials management department)
- All patient, visitor, and/or employee outcomes
  - Do not include subjective information such as personal assumptions, conclusions, opinions, and suggestions (e.g., regarding how similar incidents can be prevented in the future)
  - Do not document in the patient’s medical record that an IR form was completed
  - As appropriate for incidents involving a patient, document in the patient’s medical record an objective description of what was observed to have happened, patient assessment information, interventions performed, when the treating clinician was notified, and patient outcomes
- Verify that the IR form is accurate and sign and date the form
- Submit the IR form to the nurse manager or risk management department according to facility protocol

**Other Tests, Treatments, or Procedures That May Be Necessary Before or After Writing an Incident Report**
- The patient/visitor/employee will be appropriately evaluated and treated for injuries related to the event
- The risk management department will be contacted as needed for involvement in the investigation and/or completion of the IR documentation
- The physical condition of the patient/visitor/employee will be assessed monitored as appropriate according to medical status, facility protocol, and orders of the treating clinician
- The results of laboratory testing or other diagnostic procedures ordered in association with the incident will become available and an explanation of their results will be given to the affected party
- The involved patient/visitor/employee will be educated regarding what to monitor for and how to report abnormal clinical signs and symptoms that could be related to the incident

**What to Expect After Writing an Incident Report**
- The IR will be completed in accordance with facility protocol and forwarded to the nurse manager or the risk management department of the facility in which the event occurred
- Information in the IR will be analyzed to identify the root cause of the incident and determine changes that need to be made in the facility or to facility processes to prevent recurrence of the incident and promote overall safety and quality of care

**Red Flags**
- The treating clinician should be notified immediately when an incident involving a patient occurs, and should personally assess the patient if harm has occurred. Visitors or employees should be referred immediately to the emergency department if they have sustained harm. Depending on the degree of harm, employees may be cared for in employee health
- Failure to report incidents prevents the healthcare facility from developing and implementing policies and procedures to prevent the incident from recurring

**What Do I Need to Tell the Patient/Patient’s Family?**
- Educate the patient/visitor about what to expect as a result of the incident
- Explain when the results of any laboratory testing or other diagnostic procedures ordered in association with the condition of the patient/visitor will become available
- Instruct the patient/family how to monitor for and report abnormal clinical signs and symptoms that may be related to the incident
References


